STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157022	A. BUILDING _____ B. WING _____	C 01/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH LA PORTE VNA SERVICES	**901 S WOODLAND AVE MICHIGAN CITY, IN 46360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This was a federal home health complaint investigation. Complaint #: IN00140563, Unsubstantiated: Lack of sufficient evidence. Survey Date: 1/16, 17, 1/20, 1/21, 1/22, 1/23, and 1/24/14. Facility Number: IN005255. Medicaid Number: 200318440A. Surveyor: Janet Brandt, RN, PHNS Indiana University Health La Porte VNA Services is in compliance with the Conditions of Participation: 484.18: Acceptance of Patients, Plan of Care, and Medical Supervision and 484.30: Nursing Services as related to this complaint. Quality Review: Joyce Elder, MSN, BSN, RN January 29, 2014	G 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.